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Quality Health Care for Culturally Diverse Populations

Provider and Community Collaboration in a Competitive Marketplace

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The New York Academy of Medicine
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Jointly presented by

U.S. Department of Health and Human Services Office of Minority Health
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THE SECOND NATIONAL CONFERENCE

Conference attendees voiced a virtually unanimous opinion about the need for a second national conference. Reviewing the presentations and discussions further reinforced the benefit of a second conference for two major reasons: an acknowledgement that the conference had, in many ways, raised more questions than it answered; and the strong desire of conference attendees to reconvene to discuss in much greater depth the strategies and models that might be applied in their specific settings.

Building on the broad base of collaboration and innovation established at our 1998 conference, the *Second National Conference on Quality Health Care for Culturally Diverse Populations* will highlight federal, state, and local initiatives through plenary sessions, and offer opportunities for skills development and interactive discussions in workshop sessions. The core objective of the conference is to address the challenges and successes of implementing culturally competent services through dialogue and networking, and to use participant input to advance a national policy agenda.

Plan to attend the *Second National Conference on* **QUALITY HEALTH CARE FOR CULTURALLY DIVERSE POPULATIONS:** *Strategy and Action for Communities, Providers, and a Changing Health System* to be held **October 11-14, 2000** at the *Wilshire Grand Hotel & Centre,* **Los Angeles, CA**. For more information and to obtain a Call for Proposals, please visit our Web site at **www.DiversityRx.org/ccconf** or call **718-270-7727.**

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"The National Conference on Quality Health Care for Culturally Diverse Populations: Provider and Community Collaboration in a Competitive Marketplace" was held at the New York Academy of Medicine, New York, New York, October 1 - 4, 1998. Presented by the U.S. Department of Health and Human Services' Office of Minority Health, the New York Academy of Medicine, and Resources for Cross Cultural Health Care, the intent of the conference was to provide an opportunity for health care providers, community representatives, and policymakers to learn about practical, cost-effective initiatives for delivering high-quality health care to culturally diverse populations.

More than 400 participants from 26 states and four countries shared their experiences in presentations and discussions over the course of the two-and-a-half-day conference. This convergence of ideas and experiences reflected current efforts aimed at meeting the needs of diverse populations, elicited questions that might guide future deliberations, and revealed opinions about the value of such conferences in supporting participants' cross-cultural efforts.

This report integrates comments, presentations, and documents from the conference to summarize overall conference themes and recommendations for future efforts.

I. CONFERENCE DESIGN

Featuring 116 speakers and panelists, the conference included plenary sessions and in-depth workshops on each of four major themes:

- Integrating the needs of diverse communities into the operational and business objectives of health care organizations;
- Preparing clinicians and staff to bridge the complex issues of language and culture;
- Designing programs and adapting health systems with community participation; and
- Responding to policy and advocacy efforts to assure access and quality for diverse populations.

The conference targeted the information needs of several audiences concerned with delivering quality health care: health care managers and executives; health care professionals in practice and education; consumers and representatives from diverse communities; and individuals engaged in quality improvement policy, accreditation, and research. The 28 workshops were organized according to five concurrent tracks:

1. *Health Care Management and Organizational Improvement:* Integrating cultural competence into quality management, especially in managed care settings; improving health status and market share; addressing the costs and financing of cultural competence programs; and creating excellence in a diverse workforce.

2. *Clinical Practice and Training*: Providing practitioner tools for improving outcomes in diverse populations: integrating cultural competence into health care settings; and adapting training and education curricula to address the needs of diverse populations.

3. *Community Concerns and Expertise:* Developing strategies for effective collaboration with health care organizations and providers, and recommending approaches to successful development and implementation of service guidelines and standards.

4. *Policy and Accreditation:* Identifying emerging legal, policy, accreditation and Health Plan Employer Data Information Set (HEDIS) trends, and identifying specific quality measures used by managed care organizations.

5. *Research and Education:* Delineating current research strategies to document the impact of linguistically and culturally appropriate care on outcomes, satisfaction, efficiency, and quality.

The themes and tracks worked together to create the structure of the conference, with the themes representing the overarching conference goals and the tracks providing a consistent framework for the sessions. This intersection of themes and tracks meant attendees interested in management, for example, could attend a session on health care management and organizational improvement for each theme covered during the conference. The conference agenda provides a full listing of workshop topics and titles.

The rationale for the conference developed from the need to value cultural competence in health care as good business practice in an ethnically diverse society. The content stressed practical experience rather than theory. The rationale was based on integrating the clinical and social justice need for cultural competence into a framework that recognizes a highly competitive health care environment focused on market share and health plan enrollment. By respecting the ethical base for culturally competent actions in the health care setting, while addressing how and why such actions could be "good for business," the conference offered a unique learning opportunity for attendees.

Taking the conference from concept to reality required more than a strategy to support the meeting financially; it also was critical that the sources of support reflect the conference vision and theme. To achieve this objective, the conference presenters extended the request for assistance to a health care community defined as broadly as possible. Thus, a plan was established to solicit support from multiple sectors: foundations, the pharmaceutical industry, associations, universities, providers, and the federal government.

In the end, the conference fully achieved the sponsorship objectives. Five regional and national foundations joined three offices within the U.S. Department of Health and Human Services, three health care associations, a pharmaceutical company, and three provider organizations. These supporting organizations also formed the core of the conference advisory group, commenting on the proposed program content and format, assisting in disseminating information about the

conference, and providing overall guidance. Most important, the concerted, collaborative effort of the sponsoring organizations came to symbolize the breadth of vested and committed interests embodied in the conference agenda and its overall purpose.

II. CONFERENCE CONCLUSIONS

The National Conference presenters and participants reaffirmed the importance of and expanded the growing discourse on cultural competence in health care. Presenters especially focused on articulating the rationale for high-quality health care for culturally diverse populations and on strengthening their efforts to improve the care provided within diverse communities and to individual patients.

The following conclusions drawn from the discussions among the participants and expert presenters reflect the importance of addressing cultural competence in health care, the status of current efforts, and the challenges that remain.

1. The Growing Diversity of American Society: Implications for the Nation's Health Care System

Although cultural diversity has always been a core part of the American story, its evolution at this time is occurring in ways that distinguish it from earlier trends. These differences are evidenced in the sheer numbers, the shifts in primary countries of origin, and the fact that culturally diverse populations and communities extend far beyond the nation's cities to virtually all parts of America. Each of the world's 210 nations is represented in the U.S. population, and cultures are blending and merging continually. In fact, the draft U.S. Census for 2000 allows for 66 different categories of ethnic and racial combinations. Furthermore, the racial and ethnic terms we have adopted are becoming less and less meaningful. For example, the term "Hispanic" is becoming less and less relevant, given the great number of Spanish-speaking subcultures represented throughout the country and the inadequacy of using one label to describe them all. The manifestation of these changes has significant implications for government, politics, policy, and health care throughout the United States.

Immigration and diversity are a growing part of the economic engine that drives the United States, especially as the white population ages and as more individuals from diverse backgrounds join the middle and upper classes. Moreover, individual mobility, an ingrained feature of our society, has created diverse communities throughout the nation. As Dr. Harold Hodgkinson, director of the Center for Demographic Policy at the Institute for Educational Leadership, reminded attendees, 43 million Americans change their addresses each year, with seven million moving to a different state. As such, the contention that diversity is found only in inner and coastal cities has not been true for a long time. Today, cultural diversity is increasing throughout the Midwest, suburbs, and small towns of America. These dynamics reinforce the importance of cultural knowledge and training not only for the major teaching hospitals and city providers of care but also for caregivers and communities across the country. This growing diversity affects all aspects of the health care system and warrants action to address the health care needs of all members of American society.

2. Cultural Competence in Health Care and the Role of Government

The federal government and state governments in California, Massachusetts, Minnesota, and elsewhere are taking a more active role in assuring high-quality health care for diverse communities. Some states, such as New Jersey, have reviewed their current systems' relationship to Medicaid populations, including by addressing factors such as patient health beliefs and mistrust of providers among some ethnic groups. California has formalized cultural and linguistic requirements for health plans through an elaborate process developed with input from many sectors—advocates, community members, providers, and others. Federal efforts include introducing Medicare and Medicaid managed care plan regulations in 1998, clarifying civil rights rules with respect to interpreter programs, and detailing specific guidelines and requirements such as the need to use epidemiological data in targeting health education programs. A recent effort to develop national standards on cultural competence may provide clarity for policy makers and providers in establishing appropriate services for diverse populations.

Such efforts merit special consideration because they represent an elevation and specificity related to cultural competence that previously had been absent from state and federal policy. Nonetheless, they also raise many questions about how to ensure that policy translates into high-quality health care services. Definitions of terms (for example, the meaning of "24-hour access" for language services) and a fair balance between community need and provider or plan capacity also need clarification and careful consideration. In addition, there is a continuing need to build capacity to address cultural competence issues at the state level in particular, and to assess and disseminate experiences as they unfold. Perhaps of greatest value would be the expansion of efforts from the few states that are leaders in this area to the vast majority that have done comparatively little in assuring quality health care for culturally diverse populations.

3. Recognizing and Integrating Diversity's Dimensions into the Patient-Provider Relationship

The U.S. population's increasing diversity can profoundly affect the patient-provider relationship and the clinical encounter. Understanding generalized cultural characteristics at the group level may provide clinicians with a degree of insight into the cultural background of a patient, but providers must be careful not to make assumptions about individual patients. While cultural background obviously shapes an individual patient, so do many other factors, such as gender, sexual orientation, class, education, immigrant status, and familial status. As Dr. Harold Hodgkinson warned, "If I were you and if I had a Hispanic patient, I would never treat them on that basis. I'd want to know what country they came from and I'd want to know how long they've been in the United States. If it's been 30 days that they've been here, you've got one set of issues. If they're second generation of an immigrant family, that's something very different and you have to know those things."

Individual providers and their organizations must be knowledgeable about the patient populations they serve. The predictors of disease and effectiveness of treatments often vary by subpopulation, so effective medical care rests on understanding these differences. However, this task is becoming increasingly complex. In addition to the growing number of cultures present

across the United States, rising levels of intermarriage and multi-ethnic children have produced new cultural mixes.

To address their patients' individual needs effectively, health care practitioners must acknowledge the need for a substantially broader base of information and understanding. Clearly, knowledge of specific genetic predispositions and familiarity with the ways in which individuals from different cultures manifest certain conditions and respond to treatments are paramount to effective care. For example, according to Dr. Risa Lavizzo-Mourey, director of the Institute on Aging at the University of Pennsylvania School of Medicine, the efficacy of medications used to treat diabetes and hypertension, and to support smoking cessation varies by population group.

Practitioners' understanding of cultural issues must extend to the interpersonal relationship and individual patients' belief systems, as well. Again, Dr. Hodgkinson provided an example of some of the non-language factors that could impact communication. "High context cultures are people where the words are only a little part of it. The gestures, nuances, the eyebrows, the way people change their pitch and loudness, and how they speak" all affect the patient-provider encounter. In addition, health beliefs related to fatalism and the role of family in medical decisions, and attitudes toward authority all influence the acceptance and course of medical care.

Finally, it is important for providers to recognize the field of health care as a unique culture with its own language, attitudes, behavior, and perspective of others. Understanding this fact and attempting to view the medical system from the patient's point of view will go a long way toward improving the patient-provider relationship. Moreover, it is important for providers to realize that they bring their personal beliefs, attitudes, experiences and biases to the health care setting.

4. Cultural Diversity and Health Professions Training in the Shadow of Anti-Affirmative Action

As the cultural diversity of the United States increases, so too do efforts to expand the pool of health care practitioners from diverse cultural backgrounds. An increase in the number of bilingual/bicultural people in the health professions will result in improved outcomes for patients as well as valuable education for fellow staff.

Individual academic health centers and national organizations such as the Association of American Medical Colleges, seek to increase diversity within the health care professions, viewing this diversity as essential for patient care. Because the vast majority of health care professionals are likely to be treating patients from diverse cultures, knowledge of varied cultural medical beliefs, attitudes, and behaviors is crucial and must be taught at the earliest opportunity in training programs.

Implementing cultural competence in medical and health professions education involves not only adding courses on cultural competence but also showing students how cultural competence impinges on every other course. As Anne Fadiman, author of *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, asserts,

medical students must view cultural competence as important to patient care as learning how to use a scalpel correctly.

Professional schools also have recognized the critical role that diversity plays in the educational setting. The presence of people from diverse cultures in the academic setting provides an additional opportunity for students and faculty alike to learn more about individuals from various cultural communities.

In all, there is growing acceptance of the place for a broad and diverse cultural perspective within the health professions workforce. Anti-affirmative action policies, however, have injected great uncertainty into academic medicine's efforts to achieve greater diversity through medical school enrollment. These decisions, in large part, are resulting in substantial decreases in the number of minorities who are entering the medical field and increasing the disparity in the number of physicians who bring a native cultural perspective to medicine and health care. Without corrective measures or breakthrough innovations in recruitment, this trend likely will continue.

5. Cultural Competence in the Health Care Setting: Emerging Importance, Uncertain Direction

As cultural diversity has gained visibility in the U.S., some providers have developed targeted initiatives such as interpreter programs, recruitment strategies, and workforce training to improve their ability to serve these communities. To date, however, few rules and fewer organizational or system models have been put in place to guide health care providers in addressing cultural diversity. Instead, hospitals, clinics, and others rely on their own ingenuity to develop effective ways to transform organizations into more beneficial providers for diverse populations and communities. Many providers simply are unsure about the value of investing in cultural competence beyond cosmetic actions, perceiving little financial or market benefit in focusing on care for diverse communities and patients.

One of the first steps for many providers is to determine why cultural competence is important for the organization. Social justice or improved health outcomes are the major motivations for many providers. For others, however, business motivations for cultural competence are at least as important. John O'Brien, chief executive officer of the Cambridge Health Alliance, noted that some providers have come to realize, with the growing diversity of their communities, they must adapt to caring for these populations if they are to survive. This becomes more apparent as providers sense inadequacy in what they have done to date. For example, surveys of patients may indicate an underlying mistrust of the system that leads some to choose other providers. Health care organizations also are recognizing the proliferation of state regulations and accreditation requirements that incorporate some aspect of cultural sensitivity into their treatment plans. Still others are considering the costs and benefits of cultural competence, seeing potentially greater adherence to treatment regimens and better outcomes.

The organizational process for addressing diversity frequently requires an introspective examination to identify barriers such as institutional racism, lack of information available in different languages, and lack of staff diversity. Part of this self-examination involves the ability

to see cultural competence as a "competitive niche" that gives an organization an advantage. Board and executive management involvement is key to this internal assessment and the external review.

A second step involves developing a strategy to improve knowledge and skills among *all* staff. Some providers believe that this effort requires a systems approach that extends throughout the organization and into the community. Reaching out to the community is especially critical for gaining trust and for addressing cultural concerns. Bringing the community into the organization through membership on advisory boards, education programs, or cultural representations (e.g., paintings in waiting areas) benefits the providers and patients. Vital to these efforts are both staff and patient education: staff members need to learn about the cultures of those they care for and patients about the system of care and how to negotiate it.

It is important for health care organizations to consider how they can assist clinicians in providing culturally competent care. Specific actions on the part of health care organizations may include:

- implementation of interpreter programs and development of guidelines for the effective use of interpreters;
- development of training manuals and courses that provide information about the health beliefs, cultural practices, and folk remedies of the major cultural groups served by the organization; and
- development of medical history questions designed to elicit responses that allow the practitioner to know how to proceed in a culturally sensitive manner.

The third step involves assessing the effectiveness of cultural competency initiatives and staff actions. Such assessments can be conducted at the organizational, division, or department level. Employment of reliable assessment tools, as part of this process, is essential. Although these tools are becoming available, many are not well known and most have not been widely disseminated. Cultural competence assessment tools may gain credibility as the number of organizations using them increases and the value of the results for patients and health care settings is affirmed.

6. Managed Care Plans and the Challenge of Cultural Competence

In today's competitive managed care marketplace, with its focus on the financial margin, cultural competence can be a "difficult sell." Moreover, there are characteristics common to the design and requirements of managed care participation that may be inimical to effective care for culturally diverse patient populations. For example, shorter office visits allow less time for providers to take detailed histories and negotiate cultural issues in treatment planning. Also, provider choice may be restricted in plans with few professionals who speak specific languages or are knowledgeable about patients' cultural characteristics.

Like other health care providers, managed care organizations must embrace a business and outcomes rationale to justify cultural competence as a priority. They also may be able to use expertise in serving diverse communities as a way to differentiate themselves from other plans.

In states requiring increasing accountability for serving diverse populations, managed care organizations' attention to how they address these populations' needs may facilitate adherence to related requirements. One issue gaining increasing attention is risk management, since the liability potential of cultural incompetence can be a strong incentive for change.

If managed care organizations are serious about improving their marketing, services, and effectiveness in caring for culturally diverse enrollees, they likely will have to revisit with the board, administration, and staff, the fundamental goals of their organization to assure that linguistic and cultural competence becomes a central component of their strategy. Without this acceptance, cultural competence is likely to "get lost" among other priorities.

III. THE CHALLENGE AHEAD

The clinical, service delivery, education, government, and community priorities outlined at the conference demonstrate a broad-based concern about the future of health care for culturally diverse communities. The conference offered the opportunity to consider the actions that each perspective can use to progress in this area. However, underlying the discussion is a recognition that society is of two minds: professing a desire to recognize diversity, yet sometimes displaying a reluctance to invest in services that will properly address it.

Guaranteeing high-quality care for culturally diverse populations must remain a primary goal for health care in the United States. Too often the provider community's actions, dictated by the market and the bottom line, treat cultural competence ambivalently or as a trivial part of its "business." One difficulty is that organizations have little guidance in implementing initiatives. Similarly, many physicians are equally challenged, especially in the context of limited time and resources. Finally, society remains undecided about the importance of cultural competence as well, as evidenced by the growing success of anti-affirmative action initiatives and restrictions on services for immigrants and refugees.

Proving the value of culturally competent care, by demonstrating its effectiveness, is critical to the process of gaining wider acceptance. The challenge that lies ahead is to craft strategies for integrating linguistic and cultural competence as essential elements of the American health care agenda.

CONFERENCE PLENARY PRESENTATIONS

Four plenary sessions featuring eighteen speakers anchored the two-and-a-half-day conference and highlighted key issues presented. Each plenary session addressed one of the main themes of the conference. Summaries of the presentations follow.

Opening Remarks

Opening remarks for the conference were made by **Jeremiah A. Barondess, MD**, president of the New York Academy of Medicine; **Rosa M. Gil, DSW**, health policy advisor to New York City Mayor Rudolph W. Giuliani; and conference presenters **Dennis Andrulis, PhD,** and **Julia Puebla Fortier**.

Dr. Jeremiah Barondess welcomed the nearly 500 conference attendees to the New York Academy of Medicine. He explained that diversity matters in health care because the course of the disease is influenced by the patient's attitudes and beliefs, as well as by the patient's biological characteristics. Differences in culture also are linked with accessibility to care and outcome. Dr. Barondess concluded that, "...to some extent we have perhaps acted in the past on the basis that in health care, one size fits all. But one size does not fit all, and the clinical consequences of any disease are powerfully impacted by beliefs about that illness and beliefs about that disease, by aspects of human biology...and the ethnic psychological and socioeconomic characteristics of that patient."

Dr. Rosa Gil, on behalf of Mayor Giuliani, welcomed attendees to the "Capital of the World." In her remarks, she offered insights into the importance of educating health care providers about diverse cultures and highlighted a few of New York City's efforts.

Since many health care providers treat disease rather than illness, Dr. Gil observed, they have produced a disjunction between what is important to the patient and what is important to providers of health care. To bridge that disjunction, New York City has created innovative programs, such as medical interpretation programs, bilingual and bicultural psychiatric services, psychiatric residencies and training programs for Hispanic physicians, and immigrant registered

nurse and physician's assistant programs. Currently, New York City also is addressing the problem of uninsured patients by focusing on small businesses, because 37 percent of the 1.8 million uninsured New Yorkers, the majority of whom are minorities, work for small businesses. By early 1999, New York City hoped to have an entity in place that would offer insurance to this population and their families.

In closing, Dr. Gil offered her own insight into the complexity of the issue of cultural sensitivity. She explained that it is important to look carefully at the role of gender against the backdrop of ethnicity and culture. Women most often open the door to health care providers, bringing their children and families into the health care system.

Conference presenters **Dennis Andrulis**, director of the Office of Urban Populations at the New York Academy of Medicine, and **Julia Puebla Fortier**, director of Resources for Cross Cultural Health Care, identified the goals and purpose of the event. They noted that the foundation of the conference was built on the belief that the interdependency of community, business, government, clinicians, and health care organizations is essential to advance the quality of health care for culturally diverse populations. At the same time, in a competitive health care world that increasingly serves a diverse market, providing high-quality health care to diverse populations also makes good business sense.

Dr. Andrulis and Ms. Fortier stressed that the conference was not intended to be an end point. The conference proceedings will be disseminated to all participants, and information about the presenters, their presentations, organizations, programs, and resource lists will be added to the conference pages on the DiversityRx Web site (www.DiversityRx.org/ccconf). The Web site also will host a discussion group on cultural competence in health care. These and other activities will offer the opportunity for conference participants to exchange information, ideas, and experiences relevant to improving the quality of care for diverse populations.

In closing, Dr. Andrulis and Ms. Fortier acknowledged and thanked the conference supporters, emphasizing that the broad spectrum of financial sponsorship in itself was symbolic of the diversity represented at the meeting. Finally, they noted that this breadth of support,

representing government, private associations, business, and foundations, also symbolizes the recognition that it is time to elevate the visibility and priority of linguistic and cultural competence in health care.

How America is Changing: The Impact of Demographics and Cultural Diversity on Health Care

Harold L. Hodgkinson, PhD, Director, Center for Demographic Policy, Institute for Educational Leadership

Harold L. Hodgkinson, PhD, opened the conference with an overview of U.S. demographics presenting detailed statistics about the nation's increasing cultural diversity. Many of his observations dealt with demographic factors such as age structure, life expectancy, migration, mobility, fertility, assimilation and class; the role each factor plays in shaping individuals and our country as a whole; and the implications of these factors for health care delivery. Dr. Hodgkinson also examined racial and ethnic classification in the United States and the differences between immigrants and refugees. Finally, he provided a framework to consider when working with individuals from diverse groups.

Dr. Hodgkinson emphasized the importance of immigration for the United States. Population growth is measured by births minus deaths plus immigrants. Based on fertility rates alone, the United States is below replacement level. Immigration, however, allows the U.S. population to register growth, which is important economically and strategically. Immigration plays a crucial role in maintaining economic growth in the United States.

"The fact that immigrants come to the United States and that their children move into the middle class, buy houses, contribute to the stock market, go to college....that is the best thing that could happen to the United States," he said. The fact that immigrants tend to be young is also beneficial because the U.S. population is aging, and the age structure is skewed to those over the age of 44. Immigration serves as a balancing force against "the graying of America."

In discussing immigration, Dr. Hodgkinson underscored the very different factors influencing a refugee's entrance to America versus the traditional immigrant's reasons for coming. "Immigrants and refugees are as different as night and day. Refugees come fleeing for their lives and immigrants come seeking citizenship. There is a huge difference in how you treat people." This distinction is particularly important given the fact that the United States classifies individuals in pan-ethnic groups such as Asian or Hispanic. Particularly within health care settings, it is important to recognize the vast diversity present within these groupings because "...you can damage people by stereotypical attention to what people are supposed to behave like if they are Asian," for example, the speaker noted. "There is a difference between an upper class Chinese with two college degrees who comes to the United States and a Hmong person who fled for his life from the Laos capital to the hills. Those two are simply very different cultures. So 'Asian' will not work... in a doctor's office."

Assimilation is another important facet of diversity in America. Dr. Hodgkinson illustrated how geographic distribution and length of residence in the United States have interesting implications for assimilation, thus for overall diversity of the country. People are not distributed equally across the United States by ethnic group, economic group, nor religious group. However, "assimilation is based on the possibility of contact with the person of the different background," he said. At the individual level, the length of time someone has been in the United States often has important implications for the level of assimilation. For example, the intermarriage rates between nationality groups, a figure used to characterize level of assimilation, is high for the second generation of Hispanic and Asian immigrant groups: 35 percent of Hispanics, 45 percent of Asian men, and 54 percent of Asian women. The intermarriage rate among European immigrant groups is 90 percent.

Dr. Hodgkinson highlighted four concepts that health care professionals should consider when caring for individuals from diverse backgrounds: sense of time; role of the family; the being-doing-becoming continuum; and high-context versus low-context communication. He noted that while the United States tends to be a very future-oriented society, history is very important in many cultures. Our nation is very young when compared to societies in the Middle East, for example. For people from that part of the world, the past is sacred.

In terms of the relationship of the individual to the family, American culture is very ego-oriented, while in other cultures the family and extended family are important resources for people. In health care settings, the importance of the family often emerges in the decision-making process. While American culture tends to be egalitarian in nature, other cultures are more autocratic, with decision-making authority reserved for certain family members or community leaders rather than the individual.

The being-doing-becoming continuum should be considered in the health care setting because efforts to motivate patients to seek good health care by persuading them to look toward the future will be ineffective if the patient does not hold the same belief system. Being cognizant of various viewpoints and belief systems, and tailoring messages to them, allows practitioners to communicate more effectively with patients.

The high-context, low-context distinction, as described by W. Hall in *The Silent Language* (1945), explains that many cultures rely on far more than words to express themselves. "High-context cultures are those in which words are only a little part of communication – the gestures, the nuances, the eyebrows, the way people change their pitch and loudness, and how they speak…" are important parts of their communication, whereas all of these forms of non-verbal expression are foreign to people from low-context cultures, Dr. Hodgkinson explained. He also described the "ideal" patient as a low-context person, who answers questions in an unemotional tone, does not cry, and does not get angry.

While acknowledging the importance of race and ethnicity in the United States throughout his presentation, Dr. Hodgkinson qualified his remarks by inserting class into the equation. He presented several examples to demonstrate that class more than race affects people's actions, and to make the audience understand that it is important to look beyond race or ethnicity when interacting with others. Understanding the relationship between race and class is critical to effective health care delivery; making assumptions about individuals based on their ethnic membership alone will not benefit the clinical relationship. "So we have got to get rid of a lot of thinking that race alone or ethnicity is going to decide what people do because basically it does not," he said.

Dr. Hodgkinson's presentation illustrated how the intersection of numerous factors plays a role in defining an individual's beliefs and behaviors. In discussing variations between ethnic and racial groups, of which practitioners must be aware, he emphasized the need to view patients as individuals and to treat them accordingly.

Community Voices: Health Care Concerns of African Americans, American Indians, Asian/Pacific Islander Americans, and Latinos

Elijah Saunders, MD, Associate Professor, Department of Medicine, and Head, Division of Hypertension, University of Maryland Hospital and School of Medicine

Dr. Elijah Saunders focused his presentation on hypertension in the black population to illustrate racial and ethnic variations in disease rates and care.

Blacks have the highest rate of hypertension in the world. The disease is characterized by early onset, usually between 20 and 40 years of age, 10 years earlier than in the white population, and it tends to be more severe with more complications, such as stroke, heart attack, and kidney problems. Furthermore, because the disease is more severe in blacks than in whites with the same blood pressure level, access to care, poverty, and educational level are all correlated with late diagnosis and higher mortality rate.

Black hypertensives have a greater problem obtaining care because there are too few physicians, especially black physicians, serving minority communities. A second major barrier to treatment is that the drugs used to treat hypertension in the white population do not work as well in the black population. The bigger problem, however, is that many doctors do not know that there are racial differences in response to drugs; thus, blacks are not getting the right drugs to treat the problem. Economic factors are the third barrier to care. Cultural differences represent the final barrier to care. For instance, many inner city blacks do not trust the medical care system and get their medical advice from churches or the family.

To address the problem of lack of trust of the medical community, innovative programs have been instituted in churches and barber shops. The cooperation of the minister is essential for these

programs, because churches play an influential role in the community. Barbershops play a pivotal role as well, giving patrons the opportunity to have their blood pressure measured while getting their hair cut. Recently, programs targeting the leading women in the community also have been implemented. Lay people become trained community health workers as they are educated about hypertension, diabetes, and the importance of prevention and treatment.

The problem of hypertension in the black community reveals the influence that race and ethnicity can have on health and disease and demonstrates the need to improve research and education – education of the health care provider, the patient, and the community at large.

Clayton Fong, Executive Director, National Asian Pacific Center on Aging

Mr. Clayton Fong described the composition of the Asian Pacific community and the barriers to providing high-quality health care on a linguistically and culturally competent basis.

According to Mr. Fong, the three most important issues regarding the Asian Pacific community are that: (1) it is one of the fastest growing segments of the population; (2) it is tremendously diverse, comprising not two or three ethnic groups but 20 or 30; and (3) members of this community are underserved. In addition, he stated that the diversity of the Asian Pacific community goes beyond ethnic diversity to differences in immigrant status ranging from natives of the United States to refugees.

Mr. Fong described the complexity of the language barrier when serving the Asian Pacific community. The sheer number of languages makes it extremely difficult to provide effective service to all. He suggested that it is better to reach one or two of the groups well than to try to reach many groups poorly.

Mr. Fong illustrated his points with many anecdotes. For instance, he told the story of a health maintenance organization (HMO) that conducted a high-pressure marketing campaign aimed at senior citizens. The marketing presentations were done in Chinese or Korean, but the forms the patients had to sign had not been translated. The seniors thought they were enrolling in a

program to get free prescription drugs, only to find out later that they had to switch doctors, and received large medical bills. Mr. Fong asserted that without the infrastructure to serve those who cannot read English, such practices are not much different than bait-and-switch fraud. He emphasized that infrastructure does not mean simply translating documents; it also means having telephone operators, nurses, and doctors who speak the language available to help patients.

An important consideration to remember is that for a service to be economically feasible, the health care facility must have a certain number of patients who will use the service. However, an HMO cannot wait until it has attained that threshold of enrollees to make the infrastructure available because the threshold would never be attained; the initial patients would drop out because, without services such as those mentioned above, they would not be served well.

To illustrate the significance of the language barrier in the clinical encounter, Mr. Fong told a story about his father's encounter with an HMO. His father, who speaks Cantonese, was able to see a Chinese doctor, but the doctor spoke Mandarin. The doctor gave his father pain medication for his gout and told him to take the medication with a meal. His father did not understand that the medication should be taken with a meal and eventually suffered a perforated ulcer resulting in surgery. It would have been more cost-effective for the doctor to have spent more time with his father or for an interpreter to have been present to ensure that the patient understood clearly.

A public policy issue of larger scale is the most recent Social Security reform. Recently, Congress has been debating about changing Social Security to a two-tier system, giving benefits to those who were in this country before 1996 but not to those who arrived after 1996. These changes would affect many people in the Asian Pacific community, as they constitute one of the largest groups of recent immigrants.

Theda McPheron-Keel, President and Chief Executive Officer, Wind Hollow Foundation

Theda McPheron-Keel, known as "Red Bird," opened her presentation by providing contextual history about Native Americans. She described the impact colonization had on Native American health as well as the current socioeconomic status of the American Indian population. Ms.

McPheron-Keel then discussed Native American beliefs about health care and offered guidelines for caring for Native people.

Having never been exposed to the diseases colonists had, American Indians had no immunity and their medicines were not effective against the foreign diseases. Disease became rampant and spread through trade routes. When the traders came, they brought one of the biggest problems that Native people still face—alcohol, which was traded for furs. In the quest for alcohol, Native people killed more game than they could use, and imbalance was created. Alcoholism not only caused the individual to become sick, but also deteriorated entire families because they were left without providers. Native populations were decimated further when the United States military gave smallpox-infected blankets to the Native people and again when the buffalo herds, a primary source of food and shelter, were slaughtered. Entire tribes were killed by smallpox; survivors from the various tribes then joined together to form new groups.

Today, poverty is a way of life for many Native Americans, Ms. McPheron-Keel said. Only 20 percent of Native Americans live on reservations, while the rest live in mainstream America. During the 1950s and 1960s, Indians were relocated forcibly to the major cities under the government's relocation and assimilation plan.

Although there are more than 500 recognized tribes in this country, and just as many languages and customs, the beliefs about health care are rather similar. Many Native Americans believe that there is no separation between the family, health, and other parts of life. Everything is part of the sacred circle or cycle. The mind, body, soul, and spirit cannot be separated from health, and the family cannot be separated from the patient, literally and figuratively. When grandma goes to a clinic, the whole group—daughters, granddaughters, and others—goes and they all go into the examining room. Native Americans have their own set of unique differences that must be respected. For example, as Ms. McPheron-Keel explained, "If I had to have surgery and the doctor wanted to schedule it for Tuesday, would he understand if I told him that I cannot do it until the full moon because that is when my power is highest?"

Ms. McPheron-Keel described common assumptions health care providers make that are not helpful to the clinical encounter. For example, if diabetes is diagnosed, the patient is given insulin and shown how to take it. However, insulin must be refrigerated, although as many as 50 to 80 percent of homes on reservations did not have electricity in the last decade. Today, about 40 percent still do not have electricity and running water.

Ms. McPheron-Keel offered guidelines for providing care to Native people. First, she reminded the audience that they are not immigrants or refugees, but survivors. Sometimes it is more important for a Native person to return to his home for health care, even if the level of care is not as high. Second, Native Americans incorporate the family. Many studies have shown that family or community support increases one's chance of getting healthy and staying healthy. Third, it is important to ask questions and use humor to teach, and clinicians should explain information in a way that is respectful and relevant.

"If you come with a pure heart and ask honestly, we will be happy to teach you and show you," Ms. McPheron-Keel said. "We know that you do not know about our culture." She closed by saying that people from different cultures must learn to talk to one another and to listen. "If health care providers make themselves too distant and too academic, they create a barrier to care and will not reach those they serve."

Elba Montalvo, Executive Director, Committee for Hispanic Children and Families, Inc.

Elba Montalvo described characteristics of Latino culture, including level of acculturation and religious beliefs, that are important for health care providers to understand. She also offered a model for providing health care information to Latinos that stresses its integration with their everyday activities.

Latinos are a young and growing population, Ms. Montalvo said. By 2009, 40 million people of Latino descent will be living in the United States. The Latino community, like other groups, is not homogenous, but descends from 21 countries in which Spanish is the official language. Some of those countries have more European influence, some African, some Indian. Not all

Latinos are from rural settings; many come from very large, very urban cities. In addition, there is a wide spectrum of religion among Latinos, from traditional spiritualism to Catholicism and Protestantism.

In working with Latinos, it is important that health care providers not generalize but understand the individual's personal background and level of acculturation, as well as the different cultural traits and beliefs. For instance, many Puerto Ricans in New York City are second and third generation and have adopted American traits.

Ms. Montalvo described how her organization addressed the spread of AIDS by delivering information to the Mexican community in a collaborative effort with the Mexican consulate. Taking into consideration the fact that soccer is very important to Mexicans, health educators went to soccer fields and distributed information between games, after obtaining the permission of the president of the league and the coaches. Condoms bearing team names were dispersed, as well. To target the women, the approval of the men was first obtained, and a small feminine bag was used to distribute male and female condoms, a bottle of perfume, and information. The perfume was provided because, in traditional societies, the family comes first and women do not think about themselves, so it was to encourage them to think about taking care of themselves too.

This program is successful because it is designed around the population's culture, the services are delivered where the targeted population congregates, it involves face-to-face contact with providers who speak the same language with the same accent as the target audience, and information is provided in a friendly and non-threatening environment.

KEYNOTE PRESENTATION: The Impact of Health Care System Changes, Managed Care, and the Marketplace: Why Health Care Providers Should Incorporate Cultural Competence into Their Way of Doing Business

Risa J. Lavizzo-Mourey, MD, MBA, Director, Institute on Aging, University of Pennsylvania School of Medicine

Risa Lavizzo-Mourey, MD, MBA, presented the conference's keynote address. Dr. Lavizzo-Mourey summarized several studies that have revealed variations in the delivery of health services to different populations and provided a three-point model for culturally competent care.

Dr. Lavizzo-Mourey asserted that current discussions about diversity in health care focus primarily on the distinctions of race and gender, but that culture must be addressed when incorporating diversity into one's way of thinking. She defined culture as the body of beliefs and customs that defines a people. While culture is defined at a group level, cultural competence is applied at an individual level.

She reminded attendees that the medical community has its own cultural construct, namely a biomedical model, with each subgroup of providers subscribing to a variation of the model. For instance, the physician subculture may focus on curing disease, while nurses may see their role primarily as caregivers. In addition, within the physician community, different subcultures exist in each medical specialty. Moreover, managed care has introduced a corporate culture to medicine. All of these different subcultures within medicine, including the individual practitioner's cultural bias, have to interact effectively with the patient's culture.

Dr. Lavizzo-Mourey explained that the predictors of disease vary by subpopulation and that treatments vary in effectiveness. This understanding is important in order to target the right populations and provide culturally appropriate treatment. It is also necessary to recognize the patient's individual culture as separate from group culture. The factors that affect the culture of the individual patient are a result of the intersection of gender, sexual orientation, drug and other treatment, health risks, health beliefs, class, education, immigration status, date and reason for immigrating, and many other influences and experiences. So while it is important to understand different cultures, it is also important to see each patient as an individual.

"As we look at culture, we have to incorporate not only those beliefs that come from one's ethnicity of origin but also those that you learn as a result of mixing together with other people," the speaker asserted.

While summarizing several studies citing variations in health outcomes, Dr. Lavizzo-Mourey underscored the fact that little information exists to explain the underlying factors causing the disparities. Most of the scientific literature and research addressing disease, service delivery, and end-of-life treatment focuses on race, namely the disparity between blacks and whites, rather than culture per se. However, "race is often not the issue in understanding variation," she said. This fact has several implications for research. First, research on other cultural groups should be increased, so that we can better understand more of the differences. Next, more research is needed to examine the possible causes, reasons, or factors producing the different outcomes across groups. Such research must ask whether the disparity is the result of access issues, genetic differences, physiologic differences, cultural differences, a combination of these factors, or other factors.

Dr. Lavizzo-Mourey offered a three-point model for providing culturally competent care. She defined cultural competence as the "sense that we know how to integrate and how to use culture to our benefit…rather than to our detriment." To achieve cultural competence, Dr. Lavizzo-Mourey suggested looking at the interaction and integration of three concepts: health beliefs and behaviors, disease incidence and prevalence, and treatment outcomes.

Health beliefs and health behaviors vary by subpopulation and have a dramatic effect on health practices. "If we don't know what their underlying belief system is, we run the risk of either offending them or at least not taking into account the best way to manage a particular person's problems," she noted.

Disease prevalence and incidence affect individual diagnosis and treatment approaches because they vary by subpopulation. Based on disease incidence and prevalence, an African-American family may be counseled differently from a European-American family.

Analyzing treatment outcomes—determining what really works and whether it is different in different populations—is also a key element of cultural competence. The efficacy of medications varies by subpopulation, which has important implications for dosing. In fact, Dr. Lavizzo-Mourey explained, "The pharmaceutical industry is now increasingly taking a global approach to studying their drugs because what works in a population in New York City may not work in a population in Africa." Treatment involves not only drugs, but also patient information, she continued. "It's the context in which you give the information about diet, about exercise, about any number of non-pharmacological treatments."

In the question and answer session, an audience member suggested that Dr. Lavizzo-Mourey expand her framework of components that must be considered in patient care to include the sociopolitical construct in which health care is delivered. "The systems that have been developed, whether managed care or fee-for-service...don't really work for the diverse populations that we take care of," the audience member suggested. Dr. Lavizzo-Mourey agreed, telling the audience that her diagram would now include four circles. As a supporting example, she explained that public transportation travel time to a physician's office plays a critical role in access to care, yet ease of access by public transportation does not factor into the decision-making process when setting physician ratios for medical care groups.

Dr. Lavizzo-Mourey also was asked to comment on the impact of the anti-affirmative action movement on the health care system. She predicted that anti-affirmative action efforts would result in a continued disparity in the number of health care workers who bring the cultural perspective of different populations. She emphasized that this challenges everyone in health care to become culturally competent because it is not going to be enough to say "they can take care of their own. The numbers aren't there."

FEATURED SPEAKER: ***The Spirit Catches You and You Fall Down: The Challenges of Cultural Competence***

Anne Fadiman, Author, The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures, and Editor, The American Scholar

Ms. Anne Fadiman provided an overview of her book, which follows the case of Lia Lee, a young Hmong girl with epilepsy. In her presentation, Ms. Fadiman provided background information about Hmong culture and history, and on the experience of Hmong refugees from Laos. The story illustrates the ways in which cultural differences can serve as a barrier to quality care.

When Lia had her first seizure, her parents took her to the emergency room in Merced, California, a city with a large Hmong population. By the time they arrived, the seizure had ended. Because no interpreter was present, the Lees tried to act out what had happened, but the doctors did not understand them, and the epilepsy was misdiagnosed as pneumonia. The doctors sent her home with antibiotics rather than anticonvulsants. It was not until the third trip to the emergency room that an interpreter, a relative, was present.

The physicians who became Lia's primary caregivers were highly idealistic doctors who believed that Lia should get the same standard of care that they would give to a well-insured, upper-middle-class white patient. For example, they were so concerned with finding the perfect anticonvulsant and dosage for her that the prescription changed more than 20 times. The Lees, knowing no English, could not follow the prescription regimen because the only time they heard the dosing directions was at the hospital, where either their 10-year-old daughter or a Hmong janitor who knew English translated the instructions to them. If they forgot what was said, they could not read the label. For this and other reasons, Lia's parents did not administer the anticonvulsants regularly. The notion of a chronic illness that could not be quickly cured was very unpleasant for them. While they were sporadically giving her anticonvulsants, they also were treating her with emollients, herbal teas, and occasional animal sacrifices.

The doctors thought that the Hmong did not understand the body, and the Hmong thought that the doctors did not understand the soul. As Ms. Fadiman began to see medicine through Hmong eyes,

she realized that, like Hmong culture, it is a culture with its own traditions, its own taboos, and its own foreign language. For different cultures to understand each other better, each must admit that its own culture does not stand at the center of the universe, and each must be willing to move into the other culture. The doctors who treated Lia stayed within their culture, unable to obtain better interpreters and unaware that they could contact Hmong community leaders.

Based on her research, Ms. Fadiman concludes that the solution to dealing with culturally sensitive cases is not to abandon Western allopathic medicine, nor is it necessary to agree with the beliefs of the patient's culture. In an effort to prevent similar occurrences, Ms. Fadiman offered 10 goals that health care professionals and organizations should seek to incorporate into their service delivery systems:

1. Get more and better interpreters.
2. Encourage more children of refugees and immigrants who are both bilingual and bicultural to go into the health care professions.
3. Encourage conjoint treatment: Simultaneously incorporate allopathic medicine and whatever traditional practices your patients may wish to follow as long as they are not actually harmful.
4. Learn about the cultures with which you interact most frequently.
5. Try to see the illness from the patient's point of view.
6. Redefine your standard of care as necessary.
7. Acknowledge the humanity of the patient by acknowledging your own humanity.
8. Hold your tongue when your patient disagrees with you unless the patient's belief will make him or her sicker.
9. Act with the knowledge that good cultural communication actually improves outcomes.
10. Change what is taught in medical schools: Show how cultural competence impinges on every other course (gastroenterology, neurology, or anatomy).

Treating and Managing the Care of Diverse Patient Populations: Challenges for Training and Practice

Jordan J. Cohen, MD, President, Association of American Medical Colleges

Dr. Jordan J. Cohen presented a justification for intensifying action to create a more culturally diverse physician workforce. He described the recent history of diversity within medical school enrollment, emphasizing in particular, threats to recent progress in increasing diversity among medical professionals in the United States.

Dr. Cohen identified several core reasons for making a diverse health care workforce a national goal. He noted that because medicine is an attractive career, the opportunity to practice in the health care professions should be available to all who aspire to it. The goal of diversity offers additional value to society and health care in general. Dr. Cohen stressed that physician diversity is important to the provision of culturally competent health care because people experience illness and respond to treatment differently depending on their belief systems, cultural biases, family structures, and historical realities. In addition, managers of health care organizations that reflect the communities they serve are key to providing health care that is responsive to the needs of a diverse population. The availability of a diverse physician workforce in underserved areas is especially critical because physicians from minority groups tend to serve underserved communities at a higher rate than other physicians.

In describing the medical research environment, Dr. Cohen noted the growing need to understand how and why disease is expressed differently in different communities and to understand how and why behavioral and psychosocial factors vary across minority groups. Patient satisfaction, as well as the health of the individual, relates strongly to the level of cultural competence with which the care is delivered. Finally, as the U.S. population becomes increasingly diverse, learning how to deliver culturally competent care, including learning medicine with others and from others who embody society's diversity, will take on even greater importance.

Given these reasons for focusing on diversity in medical education, Dr. Cohen summarized the history and current status of related efforts. Before the civil rights movement in the mid-1960s, the percentage of minority medical student enrollment lagged significantly and consistently behind the

percentage of the U.S. minority population: At that time, on average, only 2 percent of medical students were from minority groups, although the minority population grew, over the same period, from 10 percent to 14 percent. Strong affirmative action programs in the late 1960s increased minority enrollment to 9 percent, but minority enrollment remained at approximately that level until 1990.

In 1990, the Association of American Medical Colleges launched Project 3000 by 2000, which sought to enroll 3,000 minority matriculants by the year 2000 (which would roughly parallel the percentage of minorities in the general population). This project also sought to develop partnerships between medical schools and teaching hospitals, as well as grade schools, high schools, and feeder colleges. Students interested in pursuing medicine were identified and were mentored and given other advantages to encourage their further education in medicine. In 1994, for the first time ever, more than 2,000 minority students were admitted to medical schools (of 16,000 students total).

Setbacks in minority enrollment in recent years have signaled the need to reinvigorate efforts to recruit minorities, however. Most notably, anti-affirmative action initiatives have begun to significantly erode improvements, and in 1997, fewer than 1,800 minority students were admitted to medical schools. To close this gap, Dr. Cohen argued for a reaffirmation of the commitment to affirmative action, and for other steps such as improving educational opportunities in the early grades to encourage students to pursue careers in medicine. Dr. Cohen concluded his remarks by stressing that, while affirmative action and enhanced opportunity will solve part of the problem, additional methods must be found to motivate students from minority backgrounds to become interested in all health professions.

Robert C. Like, MD, MS, Associate Professor and Director, Center for Healthy Families and Cultural Diversity, Department of Family Medicine, University of Medicine and Dentistry of New Jersey (UMDNJ) – Robert Wood Johnson Medical School

Dr. Robert C. Like described how he and his department have integrated the issue of caring for diverse populations into the medical school curriculum and family practice residency training. Their guiding principle is that one must look not only at the culture of the people one serves, but also at oneself.

Dr. Like noted that many health professional organizations, including the American Nurses Association and the American College of Obstetricians and Gynecologists, have published guidelines to help clinicians learn about cultural competence. He spoke in detail about the Society of Teachers of Family Medicine's "Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care," developed by Like, Steiner, and Rubel in 1996.

The core curriculum guidelines cover topics such as key sociocultural issues relating to health care, multiculturalism in the United States from a population perspective, cultural perspectives on medicine and public health, cultural epidemiology of health and illness problems of different groups, clinical practice issues, and administrative issues. The guidelines recognize that simply acquiring knowledge about culture is not adequate. Knowledge must be complemented by self-reflection and an examination of one's own often-unrecognized values, biases, and subjectivity. Furthermore, while cultural differences are important issues, issues such as age, gender, race, sexual orientation, social class, education, language, and disability status must be addressed as well, the speaker said.

Dr. Like described the development of the UMDNJ-Robert Wood Johnson Medical School Department of Family Medicine's infrastructure for addressing cultural competence issues. This infrastructure includes faculty development and medical student and residency training, and involvement in technical assistance projects with the New Jersey Department of Human Services and the New Jersey Department of Health and Senior Services. Faculty development included conducting a needs assessment, as well as discovering the faculty's own biases, through questionnaires and workshops. Medical student training involved community work and observation of doctor-patient communication. For residents, cultural issues were integrated into grand rounds, clinical precepting, case conferences, and the everyday "rituals" of clinical practice.

Dr. Like suggested a useful conceptual framework for interacting with patients that can be remembered by the mnemonic, **LEARN** (devised by Berlin and Fowkes): **L**isten with sympathy.

Empathize by sharing your perceptions. **A**cknowledge and discuss differences and similarities. **R**ecommend treatment. **N**egotiate agreement.

He also recommended another mnemonic, **ETHNIC** (devised by Levin, Like, and Gottlieb): This technique involves: **E**xplanation—Listen to the patient's story, beliefs about what causes a particular problem, why the patient thinks he or she has the problem, whether the patient thinks it is contagious, and how the patient thinks it can be prevented. **T**reatment—Ask the patient what types of treatments, including pharmacologic, herbal, and nutritional treatments, have been tried. **H**ealers—Ask the patient what other healers and health aids have been used. **N**egotiation—Develop a therapeutic alliance with the patient. **I**ntervention—Mutually develop medical, spiritual, psychosocial, or education interventions. **C**ollaboration—Ask yourself, "Whom else do I need to work with in this person's family or community?"

The development of cultural competence is a life-long journey, Dr. Like continued. Cultural competence issues that must be addressed in training health care professionals include the fear of difference, the denial of difference, the romanticization of culture, and ethical issues. Physicians must be trained to deal with cross-cultural value conflicts, and the misunderstandings that can occur because of the "personal baggage" that is brought to clinical encounters. Lastly, cultural humility is needed. Both proficiency and openness—the ability to learn from other people—are important.

Every clinical encounter is a cross-cultural encounter, the speaker concluded. As anthropologist Clifford Geertz once said, "Common sense may not be commonly shared."

Glenn Flores, MD, Assistant Professor of Pediatrics and Public Health; Founder and Co-Director, The Pediatric Latino Clinic, Boston Medical Center; Robert Wood Johnson Minority Medical Faculty Development Scholar

Dr. Glenn Flores discussed the importance of culture in clinical care and how to achieve cultural competence. He elaborated on the following topics: (1) normative cultural values that affect care, (2) clinical issues regarding language barriers and interpreters, (3) the importance of knowing about culture-specific folk medical beliefs and practices, (4) being aware of the clinical implications of patient/parent beliefs and practices, and (5) a model of care that can be applied to any cultural group.

Dr. Flores described a few of the normative cultural values of Latinos to provide examples of how cultural beliefs impact the clinical encounter. *Simpatía* involves kindness in the face of stress, or avoiding hostile confrontation. The neutral attitudes of doctors often are perceived negatively by Latino patients, as lacking *simpatía*. Consequently, the patients respond negatively, which manifests as decreased compliance, decreased satisfaction, and poor follow-up.

Personalismo is the expectation of a warm, personal relationship with the doctor. Doctors can foster *personalismo* by decreasing the space between themselves and the patient, by judicious nonverbal communication through touch, by giving the patient one's card or pager number, and by showing interest in nonclinical aspects of the patient's life.

Respeto implies that the observation of different behavioral mores for differences in age, status, gender, and authority level. This can be accomplished by involving the patient in medical decisions and by the use of titles (*señor, señora*) and formal case in Spanish. Furthermore, because Latino patients show their *respeto* by refraining from asking a lot of questions, physicians should encourage them repeatedly to ask questions.

Familismo is the value that the family and its needs are more important than the needs of the individual; hence, important decisions are made by the extended family. It is necessary for the clinician to respect the fact that clinical decisions need to be taken to the family for consideration; they cannot always be made on the spot.

Fatalismo is the belief that the individual can do little to alter fate, which often leads to the avoidance of effective therapy (e.g., for cancer) and to nonparticipation in screening tests. The clinician can address these resistances by emphasizing the effectiveness of therapies for chronic diseases and the importance of screening for the prevention of illness.

Next, Dr. Flores discussed issues regarding language barriers and the use of interpreters in clinical care. He stated that an estimated 31 million people in the United States are not proficient in English. Compared to English-proficient patients, patients with limited English proficiency tend to make fewer primary care visits, receive less preventive care (in the form of fewer mammograms and Pap smears), miss more follow-up visits, have lower compliance rates, and visit emergency rooms more often. Additionally, their children tend to have poorer health. When there is patient-physician language concordance there is evidence of improved physical function, higher levels of well-being, and lower reported levels of pain. In addition, patients in such situations ask more questions and have a better understanding and recall of information they are given.

Dr. Flores offered guidelines to follow when using interpreters. There are four basic options, each with advantages and disadvantages for interpreter use: a professional, an ad hoc interpreter, telephone interpretation services, and a friend or family member. Unless the clinician is very fluent in the language, a trained professional should be used. Strangers, untrained staff, and especially children should not be used as interpreters because of problems with accuracy (a study found that untrained family members incorrectly translated 23 percent to 52 percent of words), confidentiality, sensitive issues, and disrupted social roles. The clinician, the interpreter, and the patient should be positioned in an equilateral triangle, and eye contact should be maintained with the patient, not the interpreter. Repetition and visual aids should be used to reinforce important information. The patient should be asked to repeat important instructions (such as for medication dosage) via the interpreter to confirm comprehension. The interpreter also should write important instructions in the patient's native language.

In addition, Dr. Flores explained the importance of knowing about culture-specific folk medical beliefs and practices. Latinos who are less acculturated to American society are more likely to

adhere to ethno-medical beliefs. *Empacho*, for example, is a common ailment in which food or saliva is thought to get stuck in the stomach because of overeating or eating the wrong food at the wrong time. Its symptoms include vomiting, diarrhea, anorexia, bloating, and fever. Folk treatments often include dietary restriction, ingestion of tea, abdominal massage, and potentially harmful lead-based powders. It is important for health care professionals to know about such practices because remedies given at home might exacerbate the condition. Also, some beliefs about clinical care influence parents to avoid seeking medical care for their children. When home remedies are used, medical care often is delayed.

Dr. Flores noted that research has shown that providers give biased care to Latino patients. Latinos are given less pain medication, Latino children are screened less, and Latinos receive fewer prescriptions, even when they are in poorer health. These discrepancies exist for many reasons: (1) with lack of language proficiency, there is greater miscommunication in medical history, (2) different cultural norms about the acceptability of expressing pain result in its underexpression, and (3) social bias and racism in our culture and in the health care system exacerbate the difficulties posed by language and cultural diversity.

Dr. Flores presented a model for cultural competency consisting of four components:

- **Normative cultural values:** Identify those that affect care, and accommodate for these values in clinical encounters.
- **Language issues:** Use trained interpreters whenever possible, follow guidelines for effective interpreter use, and encourage efforts to increase the foreign language skills of staff and the English skills of patients with limited English proficiency.
- **Folk illnesses, beliefs, and remedies:** Recognize those that may affect care, suggest alternatives to harmful folk remedies, accommodate beliefs non-judgmentally into the clinical encounter, integrate such beliefs into the biomedical treatment plan whenever possible, and carefully explain the etiology and treatment rationale for a given biomedical condition.
- **Provider practices:** Maintain vigilance for ethnic disparities in screening, prescriptions, procedures, and outcomes. When disparities occur, determine the source of the problem and address any practices that might be responsible.

For those wishing greater detail, Dr. Flores's article, "Culture and the Patient-Physician Relationship: Achieving Cultural Competency in Health Care," will soon be published in the *Journal of Pediatrics*.

What Purchasers Representing a Diverse Workforce Want from Health Care Providers

Bruce C. Vladeck, PhD, Professor of Health Policy, Mount Sinai School of Medicine, and Senior Vice President for Policy, Mount Sinai Medical Center

Dr. Bruce C. Vladeck, former Administrator of the Health Care Financing Administration (HCFA), focused his presentation on the changing rationale for government promotion of culturally competent care and the implications of those changes for the future.

Dr. Vladeck noted two basic assumptions are at the foundation of the current political-legal-social climate. First, health care that is not culturally sensitive cannot be optimally high quality; and people who use Medicare and Medicaid are very diverse and becoming more so. Second, the enthusiasm for enforcing civil rights laws has diminished. In the past, the Civil Rights Act profoundly affected the Medicare program because Medicare's implementation in 1966 was used as the vehicle for desegregating hundreds of hospitals in the South. Specifically, the legal authority of the Civil Rights Act to provide open access to public accommodations or to beneficiaries of public funding addressed the more blatant and inexcusable barriers to care and had more "bite" than arguments based on cultural sensitivity. Dr. Vladeck commented that HCFA's regulation of health care facilities is founded on that basic requirement for access to services.

Dr. Vladeck pointed out that the current political/governmental environment does not support using traditional civil rights and equal protection laws when it comes to cultural diversity. He stated that HCFA has shifted its emphasis, away from access and civil rights issues to quality of care issues. HCFA's efforts now focus on assuring and improving the quality of care that is provided by organizations under contract with the federal government. For example, in the new HCFA regulations on Medicare managed care, most references to cultural responsiveness pertain

to linguistic competence in marketing and public education activities to quality assurance standards with which Medicare managed care plans must comply.

In another example, he described proposed regulations from HCFA for Medicaid managed care plans. The regulations require state agencies to ensure that managed care organizations identify significant subpopulations among their enrollees who might experience special barriers to accessing health care services, and then to improve accessibility for those groups. The regulations also state that translation services must be made available when language barriers exist; these services include the use of sign interpreters for persons with hearing impairments and the use of Braille for persons with vision impairments. Additionally, managed care organizations must have an adequate number of providers, commensurate with the subpopulation size, who know the values, beliefs, traditions, customs, and parenting styles of those groups. This knowledge includes cognizance of the importance of nonverbal communication, the recognition of dietary customs, and the existence of folk medications or healing practices that might be used by an enrollee. Providers also must have knowledge of medical risks and socioeconomic factors specific to the population, as well as epidemiologic data that may be used to create appropriate education, screening, and treatment programs. Dr. Vladeck pointed out, however, that HCFA has no authority to *enforce* the regulations, except by withholding funds.

The speaker warned that there is a danger in shifting the emphasis on cultural responsiveness from a civil rights framework to one built on definitions and measurements of quality. Although many people are committed and working toward that goal, many private payers do not really care about quality. He asserted that managed care organizations that sought accreditation in the past are no longer doing so because they would rather not risk getting a bad accreditation score and having adverse data made public.

Dr. Vladeck stressed that even if every provider of health services tried to meet not only the letter but also the spirit of regulations, a great distance would remain in reaching critical goals for diverse populations. He concluded that a satisfactory level of responsiveness to cultural diversity will not be achieved until the health care provider workforce better mirrors the patient population. Fundamentally, the issue of diversity is about power—who is in control of the health

care system. Minority issues will be dealt with adequately only when minority groups are represented in the decision-making structures. Ultimately the issues being addressed are inseparable from broader sociopolitical issues of how people live and govern each other in a multicultural world.

Federal, State, and Non-Governmental Policy Initiatives Affecting Diverse Populations

Michael Hash, Deputy Administrator, Health Care Financing Administration

Mr. Michael Hash described the Health Care Financing Administration's (HCFA) efforts to develop cultural competency initiatives throughout HCFA's programs, including Medicare, Medicaid, and the new Child Health Insurance Program. The agency's mission has three components: to provide affordable, high-quality access to services; to guarantee the protection of the rights and dignity of all beneficiaries; and to provide clear and useful information for beneficiaries and health service providers. Because HCFA is the nation's largest purchaser of direct health care services, it is incumbent upon HCFA to use its leverage in the marketplace to promote both quality and value.

In 1965, the founding principle of the Medicare and Medicaid programs was to provide improved quality of life for the most vulnerable people in our population, namely, the aged, the disabled, and those with low income. Cultural differences often create barriers that result in increased vulnerability for some aged and some poor. Although there is considerable economic diversity within established racial and ethnic minorities, many of these subpopulations remain in the low-income category. Therefore, according to its mission, HCFA must meet the challenges raised by cultural and linguistic differences.

Both culture and education shape how health care information is received and used, how rights and protections are exercised, how health problems are defined, how symptoms and concerns about problems are expressed, who should provide treatment, and what kinds of treatment are likely to be the most efficacious. HCFA uses the framework of Lavizzo-Mourey and MacKenzie, which focuses on the following three concerns: (1) it is necessary to understand the

beliefs and values of a culture in order to provide appropriate and sensitive care; (2) an epidemiological perspective is necessary in order to be aware of the prevalence and incidence of disease in the populations served; and (3) because not all treatments are effective in all populations, it is necessary to understand which treatments work best for specific populations.

HCFA has established the following three goals designed to overcome the cultural and linguistic barriers to access: (1) provide information about HCFA's health care services, (2) overcome barriers related to the exercise of rights and protections, and (3) improve health outcomes and decrease disparities within subpopulations. Mr. Hash related the following information with respect to these goals:

Goal 1: HCFA has improved access to care in several ways. In the Medicare program, the Horizon projects disseminate to Hispanic and black communities information about prevention of diseases such as influenza and pneumonia by immunization, and detection of breast cancer by mammography screening. HCFA also is obligated to do outreach to try to enroll the more than four million children who are currently eligible for services but are not enrolled. Furthermore, last year the Medicare program was amended so that HCFA can contract with a much wider array of private health care programs to give beneficiaries more choices. To ensure that beneficiaries have information that will help them choose among the health plans and programs available to them, HCFA is undertaking the largest educational program in the history of Medicare. The program uses a variety of methods, including printed material, telephone calls, the Internet, and most important, a vast network of community-based partners who provide one-on-one counseling and information.

Goal 2: A grassroots Rights and Protections outreach project is identifying ways to strengthen the participation of special needs populations, including Asian and Pacific Islanders, American Indians, and Native Alaskan populations. HCFA also is complying with President Clinton's executive order for installing the Consumer Bill of Rights and Responsibilities across all federal health programs.

- **Goal 3:** To improve the health outcomes of beneficiaries, HCFA promotes quality improvement across all of its programs through a peer review organization in each state. These organizations help target important initiatives that need to be undertaken. For example, the New Mexico peer review organization helped implement a diabetes initiative for Native Americans, with the goal of reducing the incidence of diabetes and its complications. In the Boston area, a hepatitis B initiative to reach the Chinese community was instituted. In Texas, an influenza immunization project targeted Hispanic Medicare beneficiaries. HCFA is constantly seeking to identify additional, similar projects.

HCFA also is working to hold health plans accountable for providing high-quality services through its "Quality Improvement System for Managed Care" program. Plans under this system must provide services in a culturally competent manner. In addition, HCFA is working to establish performance goals for its fee-for-service providers. Related to the President's initiative to reduce racial and ethnic disparities in health care, HCFA is pursuing community partnerships that focus on cancer screening, diabetes education and self-management, and increased child and adult immunization.

Mr. Hash closed by reiterating his commitment to integrating cultural competence into the fabric of all HCFA programs and into the operations of all its partners.

Esta-Lee Stone, Director of Clinical Projects, Massachusetts Division of Medical Assistance

Ms. Esta-Lee Stone elaborated on the Massachusetts Division of Medical Assistance Cultural Competency Initiative, which is designed to "promote and facilitate the purchase of linguistically appropriate and culturally sensitive services." Begun at the executive level and now integrated within the entire organization, the initiative includes member services, outreach and enrollment, and clinical care, and involves all participating providers, other government agencies, and community advocates. Ms. Stone's presentation focused in particular on the implementation of the Cultural Competency Initiative specific to the Hispanic population, and the state's effort to determine the need for interpreter services through a provider survey.

Data collection throughout the state revealed that medical assistance beneficiaries often have limited English proficiency and limited literacy skills. The implications of these findings are broad, impacting for example, the design of patient education materials and medication instructions for patients. In the Hispanic population, there was little familiarity with Western medicine and with health care systems and practices. Therefore, a Spanish-language television program was developed to discuss topics such as why one should go to the doctor even when one is not sick, the importance of prevention, how lifestyles affect health, and the role of primary care physicians.

The Division of Medical Assistance collected demographic data to determine the locations of populations, categorized by both the broad categories and the specific immigrant groups. Data also were gathered to determine the geographic locations where services were most needed. For instance, one project identified the disparate health outcomes among the statewide population. The results for the Hispanic population indicated that:

- The leading causes of death varied by age, as expected, but are not the same as those of other populations. The leading cause of death for children aged one to 14 years was congenital abnormalities; for ages 15 to 24, homicide and motor vehicle accidents; for ages 25 to 44, AIDS and HIV-related diseases; and for ages 45 to 65, cancer, heart disease, and diabetes.
- Hispanics had the second highest rate of diabetes and the highest rate of being overweight.
- The Hispanic population was less likely to receive prenatal care and had higher rates of infant mortality and low birth weight.

By collecting these data, the Division of Medical Assistance could better target services and better inform those who were delivering services.

To provide reimbursement for interpreter services, the Division of Medical Assistance investigated many different delivery models. However, data about health outcomes were needed in order to convince both the administration and the legislature that reimbursement was a necessary step. Thus, the state conducted the Provider Survey, which involved conducting

telephone interviews with staff at 1,523 primary care sites and at all ambulatory outpatient sites. Interviews with office staff were conducted because it was assumed that the response rate would be small if physicians or health care managers were contacted. Data were collected on issues such as the foreign languages spoken by Massachusetts Health beneficiaries, the capacity of providers to provide services in those languages, the success of providers in helping beneficiaries make and keep appointments, and the success that beneficiaries have in following treatment plans.

One of the most important uses of the Provider Survey results is to help members choose a health care system and a provider who speaks their language. The state is also planning a cost-benefit analysis of interpreter services.

Foundation, Corporate, and Government Leadership Supporting Cultural Competence Priorities and Programs

Captain Tuei Doong, MA, Deputy Director, Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services (DHHS)

Nancy H. Lang, MBA, Marketing Manager, Multicultural Markets, Health Care Systems Marketing, Hoechst Marion Roussel

Barbara Sabol, MA, RN, Program Director in Health, W.K. Kellogg Foundation

The closing panel of the conference brought together representatives from the three major sectors that provided financial support for the conference—foundations, government, and the corporate sector. The objective of the panel was to offer information on cultural competence priorities and programs of potential value to conference participants.

Captain Tuei Doong described federal government activities in promoting cultural competence. Although its primary role is to convene and articulate agendas around key issues, the U.S. Department of Health and Human Services (DHHS) has concentrated on promoting the President's Race Initiative, which is intended to eliminate racial and ethnic disparities in six health areas. This effort involves fostering partnerships and calls for a $400 million prevention program and public awareness campaign. Other DHHS activities include the White House Initiative on Historically

Black Colleges and Universities, which focuses on education and discrimination; education initiatives targeted to Hispanic Americans, American Indians, and Alaska Natives; and an action agenda to meet the health and human service needs of Asian-Americans and Pacific Islanders. Other programs within the Office of Minority Health are designed to address the public health needs of minority populations, including supporting bilingual, bicultural efforts in health care. Finally, the federal government has sponsored resource centers, including the Office of Minority Health Resource Center, which offers database searches and referrals on minority health issues.

Ms. Nancy H. Lang identified corporate initiatives within Hoechst Marion Roussel and offered guidance in developing collaborations with the pharmaceutical industry. Ms. Lang stated that the traditional history of marketing by working primarily with physicians has undergone significant change with the emergence of managed care organizations (MCOs). MCOs now represent a primary customer market; however, with increasing consumerism and the empowerment of the patient, individuals have also become the customers. As a result, pharmaceutical companies now need to explore the individual needs, including cultural needs, of patients.

Ms. Lang said that within her corporation, product managers' information needs are expanding to include knowledge of product performance in managed care, hospital penetration, physician value, and distribution. Multicultural marketing has become a priority goal that is evolving and it has involved the creation of task forces; networks of people in the field who monitor marketplace needs; and special events, such as hosting a Multicultural Marketing Day. Specific initiatives targeting the diabetic Hispanic population include providing information on the Hispanic culture as well as epidemiological information about diabetes, and a Spanish-language videotape about diabetes, which addresses patients' cultural barriers and myths that result in noncompliance. Finally, Ms. Lang identified issue areas to assist in working with sales representatives. These issue areas include clarifying business objectives; increasing knowledge of corporate involvement in therapeutic areas; building awareness of products in development; and developing successful approaches to working with physicians, nurses, and MCOs.

Ms. Barbara Sabol described the mission and origin of the W.K. Kellogg Foundation. The Foundation was founded in 1930 by Mr. Kellogg to promote the health, education, and welfare of mankind, but principally of children and youth, without regard to sex, race, creed, or nationality. Values and activities undergirding the Foundation target the most vulnerable people in society, and accentuate the importance of diversity and inclusivity; recognizing the intrinsic assets of communities, including their ability to define and solve their own problems; and valuing partnerships for improving organizations and institutions and for assuring sustainable social change.

The Foundation's health goals target improved access to a strengthened, responsive health care system, featuring affordability and comprehensiveness, and stressing health promotion, prevention, and primary care. To achieve these goals, the Foundation invests in developing the health care workforce, informing public policy, and improving access to care.

Ms. Sabol cited two health care initiatives that exemplify foundation activities and provided insight into the evaluation of grant proposals. The first initiative, *Turning Point*, is a collaboration with the Robert Wood Johnson Foundation involving 41 communities and more than 500 people from business, faith communities, and health care sectors. The participants seek to reach consensus about public health for the next century by defining and describing an appropriate array of health protection, health promotion, and preventive primary care for the whole community, including uninsured, underserved, and otherwise disadvantaged persons. The second initiative, *Community Voices*, a health care program for underserved persons, is a $55 million investment in 13 communities that promotes participation by a broad spectrum of the communities in setting the policies, programs, and direction of the health care system.

While not explicitly featured in any one program, multicultural issues have been infused in all Kellogg programming, Ms. Sabol said. The presence of partnerships, methods for community input, community involvement, and impact on the community are factors in evaluating grant applications.

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